facility is sold. On or after July 1, 1984, all owner-providers that withdraw from the Medicaid program shall be required to sign a contract with the department creating an equitable lien on the owner's capital assets. This lien shall be filed by the department with the clerk of the circuit court in the judicial circuit within which the facility is located. The contract shall specify that the method for computing depreciation recapture shall be in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to the agency upon sale of the facility. In the event that a provider fails to sign and return the contract to the department, the Proof of Financial Ability which is required for the prospective operator of the facility to be licensed shall not be approved.

(2) For lessees entering the Medicaid program after July 1, 1984 and for existing Medicaid providers who are granted an upward adjustment to their allowable lease costs after July 1, 1984, the portion of the Medicaid reimbursement rent payment that represents depreciation expense shall be subject to the depreciation recapture provisions of the plan at the time the facility is sold.

The recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Medicaid during the months that he was the Medicaid provider or a lessor to a Medicaid provider, or both.

4. Limitations on interest. For reimbursement purposes, the amount of interest allowed to a new provider in a change of ownership is limited by

the allowed basis for depreciation. If the new owner's equity in the facility is less than the allowed basis for depreciation, the owner shall be allowed interest expense on the difference between the allowed basis and the equity. If the new owner's equity in the facility is more than the allowed basis for depreciation, no interest shall be allowed.

Example 1: The original owner's acquisition cost is $1,000,000. A new owner purchases the facility in 1985 for $2,000,000, putting $500,000 down and financing $1,500,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000, and he can be reimbursed interest on $500,000 at 15 percent, that is, $1,000,000 - $500,000 = $500,000 at current rate of 15 percent.

Example 2: The original owner's acquisition cost is $1,000,000. A new owner purchases the facility in 1985 for $2,000,000, putting $1,250,000 down and financing $750,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000 which is less than the equity, so he receives no interest reimbursement.

5. Limitations on return on equity ROE. Return on equity is also limited by the new owner's allowed acquisition cost. The new owner can receive a return on equity based upon his actual equity, up to the allowed acquisition cost.

Example 1: The original owner's acquisition cost is $1,000,000. A new owner purchases the facility in 1985 for $2,000,000, putting down $750,000. The new owner's allowable depreciation basis is $1,000,000, and he can receive ROE reimbursement on the $750,000.

Example 2: The original owner's acquisition cost is $1,000,000. A new owner purchases the facility in 1985 for $2,000,000, putting down $1,250,000. His equity amount for reimbursement purposes shall be limited to $1,000,000.

6. Property-related costs allowed for reimbursement purposes shall be limited by the following provisions.

a. Costs that are capitalized as per HCFA PUB.15-1 (1993) provisions other than land, buildings, construction loan costs, and equipment shall not exceed what a prudent and cost-conscious buyer would pay for the given service or item. If such costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, HCFA PUB.15-1 (1993), and this Plan to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursed under the plan. Examples of such costs include but are not limited to legal fees, developers' fees, underwriters' fees, bond discount, loan points, trustee fees, interest cost on debt reserve requirements, and costs of feasibility studies.

b. All allowable capitalized costs included in (a) above plus all interest costs incurred as a result of financing the land, building, and equipment, including building equipment, major movable equipment, and minor equipment as described in HCFA PUB.15-1 (1993), shall be limited in total to the amount of interest cost that would be incurred if the land, building, and equipment had been financed through a "conventional financing" debt instrument over a 25-year period, with a 10 percent cash down payment, at an interest rate equal to the lesser of 15 percent or the prime rate plus 2 percent. In cases where the provider obtained greater than 90 percent financing, the difference between the actual down payment and a 10 percent cash down payment in this financing limit method shall be included with the balance sheet average equity for the period for purposes of computing an incremental change in return on equity or use allowance that would have occurred had a full 10

percent down payment actually been made. If the total ROE payment would increase from zero payment to a positive dollar amount, then the financing cost limitation on interest expense shall increase by that positive dollar amount. If the total ROE payment would increase from a positive payment to a greater amount, then the financing cost limitation on interest expense shall increase by the difference between the two amounts. For purposes of this provision, the "conventional financing" amortization schedule used shall provide for equal installments, that is, payments, with amortization of the principal beginning in the first year, that is, a 25-year payoff schedule. The prime rate used shall be the prime rate as stated by the Chase Manhattan Bank in New York as of: the date the provider received a loan commitment from the lending institution; or the date AHCA received the provider's acceptable budgeted cost proposal if no commitment date can be documented. Providers with variable rate debt instruments that are initially approved within these cost limitations shall be granted cost increases due to an increase in their interest rate, but not to exceed that cost which would be incurred at an interest rate of 15 percent per annum.

c. Additional costs due to refinancing shall not be allowed if refinancing was not necessary in order to meet the final payments of the former debt instrument, that is, in cases where balloon payments are due, or to finance the addition of new beds.

d. AHCA shall make exceptions to the financing limitations set forth in (a) and (b) above when, in the judgment of the Office of Developmental Services, it is in the best interest of the State. Exceptions to the financing limitations shall be considered when it

has been demonstrated through the Certificate of Need or Request for Proposal process that financing within the limitations of this plan is not available.

Should that decision be made, the DCF Office of Developmental Services shall issue a new Request for Proposal allowing other financing options. DCF shall reject any or all proposals which are made in response to a new Request for Proposal if the department determines that the rejection is in the best interest of the State.

7. After June 30, 1984, additional costs incurred after enrollment in the program that are due to capital additions or expansion must have prior approval by the DCF Office of Developmental Services if such costs exceed 1 percent of the provider's current total reimbursement rate, with the exception of the addition of new beds which are approved through the state's Certificate of Need process. Costs for specific expansion or additions that exceed the 1 percent limit shall not be reimbursable if not previously approved. Further, financing costs for approved expansions or additions shall be limited by the prudent buyer limits established in Section III.G.4. above.

8. Depreciable basis as a result of capital improvements. If capital improvements are made to a facility after July 18, 1984, the actual cost of the improvements shall be added to the owner's basis, allowing the owner reimbursement of interest, return on equity, or both as specified in Section III of this plan.

9. Retirement and replacement of outdated equipment. Upon a change of ownership of a facility, the new provider must maintain the original owner's records of capital assets. If the new owner subsequently retires outdated equipment, the original owner's cost minus any depreciation shall

be an allowable write-off. Replacement equipment costs shall be allowed according to capital improvement rules as specified above.

H. Return on equity

A reasonable return on equity capital (ROE) invested and used in providing resident care shall be defined for purposes of this plan as an allowable cost. This return on equity shall use the principles stated in Chapter 12, HCFA PUB.15-1 (1993), except that the rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the Medicaid program. ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis.

I. Use Allowance

A use allowance on equity capital invested and used in providing resident care shall be defined for purposes of the plan as an allowable cost. The use allowance shall be allowed only for non-profit providers, except for those facilities which are government-owned. This use allowance shall use the principles established in Section H. above.

IV. Standards

A. In accordance with Chapter 120, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.

B. Reimbursement rates shall be established prospectively for each individual provider based on the most recent historic costs, but historic costs shall be limited

to allowable percentage increases from period to period, as described in L. below. Further, if certain costs are determined by the AHCA Office of Medicaid or the AHCA Office of Audit Services, utilizing the Title XVIII Principles of Reimbursement, HCFA PUB.15-1 (1993) and this Plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.

C. Prospective payment rates shall be established semi-annually on April 1 and October 1. The most current acceptable cost report received by the agency by February 1 and August 1 shall be used in the rate-setting process to set rates effective on April 1 and October 1, respectively. The rate-setting process is detailed in Section V of this plan. The same cost reports used for the April 1, 1998 rate semester or the most current cost report received by August 1, 1998 by the agency shall be used to establish rates effective October 1, 1998 through March 31, 1999.

D. Reimbursement rates shall be calculated separately for two classes. The classes shall be based on the four levels of ICF/MR-DD care as defined in Chapter 59G-4.170 F.A.C. The four levels of care, listed in ascending order of handicap severity, are Developmental Residential, Developmental Institutional, Developmental Non-ambulatory, and Developmental Medical. Developmental Residential and Developmental Institutional shall constitute one class for reimbursement purposes, while Developmental Non-ambulatory and Developmental Medical shall constitute the other. All providers must allocate costs by the four levels of care in their cost reports. The agency shall monitor placements of clients to determine whether discrimination against clients with higher cost or more complex service needs is occurring. If the agency determines that such placement discrimination is occurring, this plan may be amended to provide for payments based on four levels of care.

E. For the two classes described in D. above, four components of the total reimbursement rate shall be calculated separately. These four components are operating costs, resident care costs, property costs, and return on equity costs or use allowance, if applicable. Inflation allowances used in the rate-setting process shall be applied to the operating and resident care cost components independently for the two reimbursement classes.

F. The prospectively-determined individual provider's rates shall be adjusted retroactively to the effective date of the affected rates under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rates.

2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would effect a change of 1 percent or more in the total reimbursement rate. The amended cost report must be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 30 days after the exit conference between field audit staff and the provider has been completed.

3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.

G. The following provisions apply to interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process described in Section V, as well as to changes in a provider's allowable cost basis. These provisions are not applicable to new providers' first year interim rates, which are addressed in sections H. and I. below.

1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition,

repair, or replacement would cause a change of 1 percent or more in the provider's total per diem reimbursement rate.

2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (1) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of 1.0 percent or more in the provider's current total per diem rate. The provider must submit documentation showing that the changes made were necessary to meet existing state or federal requirements.

3. In the event that new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require all affected providers to make changes that result in increased or decreased resident care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by the agency and shall be the basis for establishing reasonable cost parameters.

4. Interim rate requests resulting from (1), (2), and (3) above must be submitted within 60 days after the costs are incurred, and must be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement

rate paid to the provider shall be the sum of the previously-established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request subsequent to June 30, 1984, the AHCA Office of Medicaid must determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid must approve or disapprove the interim rate within 60 days. If the Office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

5. Interim Rate Settlement.

Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Under-payment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. After the interim rate is settled, a provider's cost basis shall be restricted to the same limits as those of a new provider per Section I. below.

6. The right to request interim rates shall not be granted for fiscal periods that have ended.

H.1. For a new provider in a facility with greater than six beds, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited as follows:

A. Property Costs:

Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

B. Operating Costs: